Supreme Court, U.S.
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No._____

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 2006

LINDA PRALUTSKY f/k/a/ LINDA RITZER,

Petitioner,

v.

METROPOLITAN LIFE INSURANCE COMPANY,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES SUPREME COURT OF APPEALS FOR THE EIGHTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Under ERISA, can a claim administrator reasonably deny long-term disability benefits to a claimant based upon a non-existent "objective proof of disability" requirement therefore relying solely on a definition of disability that was never written in the plan or communicated to the claimant prior to final denial?

2. What standard determines when an "objective evidence" requirement may be "read into" a plan by interpretation when that requirement is not found in any plan document?

3. What notice must a plan administrator provide to a plan participant of the objective evidence requirement, when it is not contained in any plan document, to ensure the participant has adequate time to respond to such a request?

4. What role can an unwritten objective evidence requirement play in the face of an entirely subjective disease such as fibromyalgia?

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Pralutsky v Metropolitan Life Insurance Company, 435 F.3d 833 (8th Cir. January 19, 2006), a copy of which is incorporated in the Appendix.

Pralutsky v. Metropolitan Life Insurance Company, Refusal of Hearing En Banc dated March 20, 2006, a copy of which is incorporated in the Appendix.

BASIS FOR JURISDICTION IN THIS COURT

Linda Pralutsky ("Ms. Pralutsky") brought a claim for long term disability benefits under her employer's group LTD plan insured by Metropolitan Life Insurance Company ("MetLife"). MetLife denied the initial claim On December 11, 2001 asserting that the medical information provided "did not support severity of a diagnosis for fibromyalgia nor did it support you are aggressively treating under appropriate care for said diagnosis." Pralutsky appealed and MetLife made a final denial in a letter dated April 11, 2002 asserting an "objective evidence" requirement stating that there was "essentially no objective medical findings to support the pathology in the musculoskeletal or neurological systems." The final denial letter was MetLife's first notice to Pralutsky that MetLife considered "objective evidence" a plan requirement because nothing in the plan language described such a requirement.

Pralutsky commenced a lawsuit in state court on July 7, 2003 alleging breach of contract. Defendant, MetLife, timely removed to Federal District Court pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e) on July 31, 2003.

The District Court, the Honorable Richard Kyle presiding, granted summary judgment for Pralutsky and denied summary judgment for MetLife on May 3, 2004.

Judge Kyle ru[illegible]hat MetLife's imposition of an objective medical evidence requirement was a serious procedural irregularity that required a less deferential standard of review. He held alternatively that, even under an abuse of discretion standard of review, MetLife's denial was arbitrary and capricious. Specifically, requiring objective medical evidence was arbitrary and capricious in this case where her illness, fibromyalgia, is a subjective disease for which objective evidence would not exist. Further, Judge Kyle concluded that the record contained ample evidence of Pralutsky's disability.

In a split decision dated January 19, 2006, a panel of the Eighth Circuit Court of Appeals reversed on two grounds. First, the panel majority ruled that denying Pralutsky's benefits, based upon an objective evidence requirement, was not a serious procedural error. Then, applying the deferential abuse of discretion standard of review, the panel majority determined that MetLife reasonably denied Pralutsky's LTD benefits based solely upon a lack of objective evidence of disability.

Judge Bye dissented. He agreed that this case should be reviewed under the abuse of discretion standard of review but disagreed that MetLife's denial, based solely upon an objective evidence requirement, was reasonable. Judge Bye

opined that MetLife denied based solely upon a lack of objective evidence that Pralutsky *could not* work yet failed to provide adequate evidence that Pralutsky *could work* because the only evidence was MetLife's reviewing doctor's assessment that Pralutsky should be able to work, an assessment that was based solely on the lack of objective evidence and not the record as a whole. He specifically noted that it was an abuse of discretion to deny a claim based solely on a lack of objective evidence when the subjective complaints are not contradicted by, or inconsistent with, other record evidence.

Pralutsky timely petitioned for a rehearing en banc on February 1, 2006. Rehearing en banc and rehearing by panel was denied on March 20, 2006.

This Petition is filed within 90 days after entry of the Order denying Petition for Rehearing by Panel and for Rehearing En Banc as required by Rule 13, and further defined by rule 30.1, of the United States Supreme Court Rules.

The Statutory provision conferring on the Court jurisdiction to review by a writ of certiorari the opinion of the Eighth Circuit and resulting judgment is 28 U.S.C. § 1254, which provides:

Cases in the courts of appeal may be reviewed by the Supreme Court by the following methods:

> (1) By writ of certiorari granted upon the petition of any party to any civil or criminal case, before or after rendition of judgment or decree; ...

STATUTES INVOLVED

The statutes include the following:

29 U.S.C. § 1132(a), which provides:

(a) Persons empowered to bring civil action

A civil action may be brought—

(1) By a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights under the terms of the plan;...

STATEMENT OF THE CASE

The basic dispute in this case is whether or not the Defendant, MetLife, acted arbitrarily and capriciously in denying Plaintiff Linda Pralutsky's long term disability benefits by unreasonably requiring objective evidence of

disability when Ms. Pralutsky suffers from a purely subjective disease, fibromyalgia.

The history of Ms. Pralutsky's case is best illustrated through the following timeline:

July 31, 2001	Due to her increasing symptoms, Ms. Pralutsky ceased working at her job at HealthEast as a Health Unit Coordinator at the Woodwinds Hospital Emergency Room on July 31, 2001, becoming disabled by fibromyalgia and chronic fatigue syndrome. She was covered under HealthEast's Group Long Term Disability Plan issued by Defendant MetLife. Because her disabilities prevented Plaintiff from performing the material and substantial duties of her job as a Health Unit Coordinator, MetLife provided her Short Term Disability benefits.
August 10, 2001	After several treatments and medical procedures, her treating physician, Dr. Omar Tveten, filled out an Attending Physician Statement (APS), as

requested by MetLife, advising Ms. Pralutsky not to return to work. His reasoning behind her inability to perform her job duties included weakness and pain.

September 28, 2001 — Dr. Tveten wrote another note to MetLife representative Cheryl Ferris indicating that Ms. Pralutsky had been, and continued to be disabled since July 31, 2001. He indicated that she has seen a number of specialists, but at that point had no specific definition or diagnosis of her condition and, as a result, she was unable to work.

October 4, 2001 — Dr. Tveten followed that up with another note to MetLife indicating that Ms. Pralutsky had been unable to work since July 31, 2001 due to a condition of severe pain that was migratory in nature, coupled with fatigue with extreme weakness. He noted that approximately two hours

after she started a typical day, she would be unable to care for herself.

October 9, 2001 — At the request of Dr. Tveten, Ms. Pralutsky was seen by Dr. Charles Ormiston of Neurological Associates of St. Paul. Dr. Ormiston felt that Ms. Pralutsky best fit into either a chronic fatigue or fibromyalgia category.

Also, on that date, at the request of MetLife, Dr. Ormiston filled out an Attending Physician Supplemental Statement, recommending that Ms. Pralutsky not return to work based on his diagnosis of "severe fibromyalgia and lower extremity pain with possible chronic fatigue syndrome."

November 19, 2001 — Dr. Ormiston wrote a follow-up letter to Dr. Tveten indicating that Ms. Pralutsky fit best in the fibromyalgia category. Dr. Ormiston mentioned that she continued to be very fatigable and was able to get only two good hours out of any single day.

December 11, 2001	Despite the repeated medical opinions of Dr. Tveten and Dr. Ormiston, MetLife denied Ms. Pralutsky's claim for long term disability benefits. Ms. Pralutsky subsequently appealed.
February 22, 2002	Dr. Tveten wrote a third letter on behalf of Ms. Pralutsky, to MetLife, indicating that she continued to be totally disabled under the working diagnosis of fibromyalgia, with elements of chronic fatigue syndrome. He indicated that there were days that she is in so much pain that it is difficult for her to even get out of bed. He noted that when she did get out of bed she would maybe be able to function for about two hours before becoming utterly fatigued to the point of being forced to lie down. He agreed that both he and Dr. Ormiston felt that there were very poor treatments for her condition and, that it had been frustrating for everyone involved. He noted that

traditional treatment such as antidepressants and anti-inflammatories had been tried but with a poor response. It was his hope that treatment of this condition will lessen her symptoms but as of that date, February 22, 2002, she was still totally disabled.

April 8, 2002 MetLife sent Ms. Pralutsky's medical records to their own independent physician, Dr. Chee Hao Chou, who was limited in his evaluation by the only two questions MetLife asked:

1. Is the employee's self reported functional ability substantiated by the clinical documentation?
2. Is the claimant's diagnosis supported by clinical objective findings?

In his answers, Dr. Chou determined that Ms. Pralutsky's symptoms were self reported without support of objective medical findings however, he agreed that she did suffer from

fibromyalgia stating that "due to the presence of generalized pain for more than three months and the description of her pain and the associated symptoms, Ms. Pralutsky's symptomatology is consistent with fibromyalgia."

April 11, 2002 — MetLife sends a final denial letter to Ms. Pralutsky stating that she did not have objective testing to support the pathology of fibromyalgia or support for a disabling condition. Ms. Pralutsky then commenced a lawsuit against MetLife seeking recovery of her long-term disability benefits.

The basis of federal jurisdiction in the District Court of Minnesota is 29 U.S.C. 1132(e) which states:

> (1) Except for actions brought under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary, or by a participant, beneficiary, or fiduciary. State courts of competent jurisdiction and

district courts of the United States shall have concurrent jurisdiction of actions under subsection (a)(1)(B) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

ARGUMENT SUPPORTING ALLOWANCE OF THE WRIT

The Panel Majority's Decision Does Nothing To Help Clarify this Court's Jurisprudence in this Area.

The majority's decision upholding MetLife's denial, based solely upon a lack of objective evidence which was not a written plan requirement, does not in any way clarify the confusion among the District Courts and the Circuits. This decision will only lead to increased litigation because of confusion among the plans, the participants and the courts as to when and why an objective evidence requirement is ok and when it is not. Put another way, the majority's decision

gives plan participants, plan administrators, the district courts and the circuits no guidance into:

- What standard determines when an "objective evidence" requirement, that is not in any plan document, may be "read into" a plan by interpretation?
- What notice must a plan administrator provide to a plan participant of the objective evidence requirement, when it is not contained in any plan document, to ensure the participant has adequate time to respond to such a request?
- What role can an unwritten objective evidence requirement play in the face of an entirely subjective disease such as fibromyalgia?

There are many, many cases, in all circuits, that illustrate the continued struggle with the objective versus subjective evidence argument and the weight that should be afforded to each. The Eighth Circuit itself is split on this issue having addressed it differently on numerous occasions.

In *House v. Paul Revere Life Ins. Co.*, 241 F.3d 1045 (8th Cir. 2001), this Court reversed a grant of summary judgment for the insurer when it denied benefits because the claimant "failed to provide any objective medical findings [or] test

data" to support a disability claim. *Id.* at 147. In so deciding, the Court said that:

> Even if the exhaustive supporting documents [the doctor] submitted could be dismissed as subjective, nothing in the terms of the plan support[s] the [insurer's] demand for "objective medical evidence."

Id. at 148. Later, in *Wilkins v. Hartford Life and Accident Insurance Co.*, 299 F.3d 945 (8th Cir. 2002), the Eighth Circuit cited approvingly to the Third Circuit's decision in *Mitchell v. Eastman Kodak.*, 113 F.3d 433, 441-43(3d Cir. 1997), holding that requiring objective evidence was an abuse of discretion. In *Mitchell,* the Third Circuit concluded that an ERISA plan administrator abused its discretion in denying benefits. *Mitchell v. Eastman Kodak.*, 113 F.3d 433, 441-43(3d Cir. 1997), In *Wilkins,* the Eighth Circuit criticized Hartford personnel for denying the claim based on the same reasons critiqued by the court in *Mitchell,* primarily a lack of 'objective medical evidence' of CFS. *Id.* at 947 n.1; see also *Mitchell,* 113 F.3d at 422. ("Because the disease, although universally recognized as severe disability has no known etiology, it would defeat the legitimate expectations of plan participants in the Kodak Plan to require those with CFS to make a showing of clinical evidence of such etiology").

In *Walke v. Group Long Term Disability Ins.*, 256 F.3d 835 (8th Cir.), the Eighth Circuit held that even though the claimant's stress was subjective and an unquantifiable factor that could not be correlated with objective medical evidence to establish disability it did not preclude him from recovering benefits. In *Collins v. Continental Cas. Co.*, 87 Fed. Appx. 605 (8th Cir. 2004) the Court held that it was an abuse of discretion for a plan administrator to ignore the claimant's self reported symptoms of chronic and disabling pain. The *Collins* Court noted that a plan administrator may not deny benefits simply because the only evidence of a disabling condition is subjective evidence. *Id.* at 607.

In *Payzant v. Unum Life Insurance Company of America,* 402 F.Supp.2d 1053 (2005), the District Court of Minnesota held that the plan in that case merely required the plan participant to submit proof of claim but did not require the claimant to provide objective evidence of disability and that requiring such objective evidence constituted a procedural irregularity.

The Court in *Slupinski v. First Unum Life Ins. Co.,* 2005 WL 2385852 also stated that subjective pain from an underlying impairment known to cause such pain, that is verified by a doctor, is enough, by itself, to support a finding of disability.

And, in *Brigham v. Sun Life of Canada*, 317 F.3d 72 (1st Cir. 2001), the First Circuit has acknowledged that laboratory tests or diagnostic procedures would not always be necessary to substantiate a claim of disability as some conditions are not susceptible to such objective evaluations. In the *Brigham* case the court ultimately upheld a benefit denial based upon a changing diagnosis, not a lack of objective evidence.

In contrast, the Eighth Circuit has also said that reliance on objective evidence is allowed. In *Coker v. Metropolitan Life Ins. Co.*, 281 F.3d 793 (8th Cir. 2002), for example this Court held that when applying an abuse of discretion standard it is reasonable to require objective evidence when the reason for a disability determination is questionable. Likewise, in *McGee v. Reliance Standard Life Ins. Co.*, 360 F.3d 921 (8th Cir. 2004), this Court held that an objective requirement was not objectionable when there were differing or conflicting opinions from a claimant's treating physicians.

The Tenth Circuit has established that at best medicine is an inexact science and that the great weight of evidence should not be merely disregarded because laboratory objective diagnostic findings were either not within the state of the art or were inconclusive. *Gaylor v.*

John Hancock Mut. Life Ins. Co., 112 F.3d 460, 467 (10th Cir. 1997). Yet, inexplicably, the District Court of Utah has used this language to determine that requiring proof that is satisfactory to the plan administrator could include an objective proof requirement. *Landheim v. The Prudential Insurance Company of America,* 2006 WL 878715.

This difference of opinion shows that the precedent, at best, is confusing and specifically unclear regarding objective evidence in the context of purely subjective diseases like fibromyalgia. In its decision, the panel majority did nothing to explain why a plan administrator can add language requiring objective evidence and then, deny a claimant benefits based solely the lack of objective evidence, when there was significant subjective medical evidence, of an entirely subjective disease, submitted by the claimant and her doctors, just as the plan documents require.

This is specifically what Judge Bye specifically pointed out in his dissent. He made it clear that it was an abuse of discretion to deny a claim based solely on a lack of objective evidence when the subjective complaints are not contradicted by, or inconsistent with, other record evidence.

The Eight Circuit has only confused the issue further in a subsequent decision. In *Johnson v. Metropolitan Life Insurance Company*, 437 F.3d 809 (8th Cir. 2006),The Eighth

Circuit specifically said that a plan administrator may require objective evidence of a disability, even when the alleged disability stemmed from fibromyalgia, so long as the administrator notified the claimant that her file lacked the required objective evidence. This statement only goes to prove that the majority panel erred in Ms. Pralutsky's case. In the case at hand MetLife did not inform Pralutsky that she needed objective evidence until their final denial letter of April 11, 2002. At that point she is barred from introducing any additional evidence into the administrative record. In their initial denial letter of December 11, 2001, MetLife stated as follows:

> We are unable to substantiate disability so severe to preclude you from returning to your own occupation on a full time basis throughout the elimination period and beyond. Medical documentation does not support severity of diagnosis for fibromyalgia nor does it support you are aggressively treating and under appropriate care for said diagnosis. Therefore, benefits are denied.

In *Abram v. Cargill Inc.*, 395 F.3d 882 (8th Cir. 2005), the Eighth Circuit has held that as part of full and fair review under ERISA, a claimant must be given all relevant information regarding the plan and the administrative review process so that the claimant can "adequately prepare [her]self for any further administrative review, as well as an appeal to

the federal courts. The *Abram* court cited 29 U.S.C. § 1133 which states:

> An employee benefit plan governed by ERISA must:
>
> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
>
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

In Pralutsky's case MetLife did not raise the objective evidence requirement until its final denial on April 11, 2002. Besides the new requirement, the numerous misspellings and confused sentence structures within the letter by themselves make it very difficult for a claimant to read and understand. To a normal reasonable person it is hard to see why she was denied. To expect her to pick out a non-existent objective requirement when all they said was that her diagnosis was not severe enough to be fibromyalgia and that she was not seeking appropriate care is unreasonable especially since MetLife's final denial was the first time the word "objective" was ever used. It was not until the summary judgment briefing that MetLife acknowledged,

even though their treating doctor had done so three days prior to their final denial letter, that Pralutsky had fibromyalgia. That is when they changed their argument to focus on this "lack of objective evidence of disability" argument. Waiting until after the claimant has submitted all of the proof she can and is unable to provide additional "objective medical evidence" is not the full and fair review that the ERISA statutes had in mind.

The Eighth Circuit has thoroughly confused the issue of when objective evidence is and is not allowed and, having never adequately addressed when objective evidence can read into a plan, none of the Circuits have ever given reasonable standards for informing plan participants what is expected in order to meet the newly interpreted requirements of the plan. Without these guidelines, plan administrators can continue to sandbag claimants by denying benefits based on plan "requirements" that have never been adequately defined or written down.

Pralutsky was asked for "proof" of her disability as outlined in her plan. Pralutsky provided proof as requested and Pralutsky's doctors provided proof as requested. Yet, MetLife denied based solely on the phantom "objective proof" requirement that did not exist in the plan. In fact, it did not exist in MetLife's first denial letter dated December

December 11, 2001 either. After that letter Pralutsky went back to her doctors and they provided more information of her condition and her disability. The "objective" evidence requirement did not exist until the final denial letter of April 11, 2002. Without some clear rule as to when plan administrators must inform claimants of the plan's expectations regarding proof, the scales are now tipped unfairly in the insurance company's favor.

In the Case of Purely Subjective Diseases, What is Objective Medical Evidence?

The Circuits have recognized that diseases like fibromyalgia and chronic fatigue are purely subjective diseases that cannot be diagnosed by objective testing. In *Sarchet v. Chater,* 78 F.3d 305 (7th Cir. 1996), the Seventh Circuit said that fibromyalgia is:

> A common, but elusive and mysterious disease, much like chronic fatigue syndrome, with which it shares a number of features. Its cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective. There are no laboratory tests for the presence or severity of fibromyalgia.

Id at 306-307. The *Sarchet* court also recognized that, when dealing with a subjective disease like fibromyalgia, denying benefits based solely on objective evidence was unreasonable. *Id.* at 307.

In *Hawkins v. First Union Corp. Long Term Disability Plan,* 326 F.3d 914 (7th Cir. 2003), Judge Posner discredited the reviewing physician's report (the same physician MetLife used here) because, in Judge Posner's words:

> The gravest problem with Dr. Chou's report is the weight he places on the difference between subjective and objective evidence of pain. Pain often and in the case of fibromyalgia cannot be detected by laboratory tests. The disease itself can be diagnosed more or less objectively...., but the pain it produces cannot be. It is "subjective" -- Dr. Chou seems to believe, erroneously because it would mean that fibromyalgia could never be shown to be totally disabling,...that because it is subjective, [plaintiff] is not disabled.

Hawkins, 326 F.3d at 919.

So, in the face of a purely subjective disease what can be construed as objective evidence? The panel majority gives no direction and the Circuits themselves give no direction. Pralutsky and her doctors provided APS forms with specific restrictions, as requested by MetLife. Her doctors wrote several letters to MetLife, on her behalf explaining their diagnosis, treatments and the affects her disabling condition had on her life. MetLife utilized a reviewing doctor who agreed with Pralutsky's treating physicians as to the diagnosis. By ignoring this substantial evidence, the panel

majority further confused what is proper evidence, objective or otherwise, in these types of cases.

In its decision the Eighth Circuit noted that MetLife advised Pralutsky to seek a referral to a rheumatologist and to consider physical therapy or aqua therapy but, this is not MetLife's duty as plan administrator. More importantly, the panel majority incorrectly turns the argument that MetLife could have had Pralutsky undergo a residual functional capacity exam into a requirement that Pralutsky should have pursued this additional testing.

In most, if not all, of these cases the claimant has been required to go through an administrative process that takes months and even years to complete. During this process, most claimants continue to be out of work for a significant amount of time and are either forced to pay for their own health insurance or, as in many cases, lose their health insurance coverage all together. Claimants are forced to budget their treatments just as they do their food and utilities. They may not be able to attend regular treatments or get prescription medication. Requiring them to now go out and pay for expensive, non-therapeutic testing in order to prove their disability, when their treating physicians have already tested, diagnosed and thoroughly assessed their

disabling condition and have sent in the forms, notes, and letters required, is not reasonable.

Claimants are at the mercy of their doctor. Sure they can ask for referrals but requiring non-therapeutic testing is unreasonable. In Pralutsky's case, her treating doctor referred her to a specialist who agreed that she had extreme limitations due to her fibromyalgia. Numerous standard fibromyalgia treatments were tried with no success. Her doctors felt it was in her best interest to take a more conservative approach to see if she would improve. MetLife's reviewing physician agreed that although there were some additional treatment possibilities, Pralutsky was under "appropriate and regular medical care at this time." The reason she was denied her LTD benefits was based solely on a lack of "objective" evidence which, in this case, was not possible and NOT in her policy nor communicated to her until her final denial. It is unreasonable to expect claimants to go outside of their treating doctor's recommendations and unreasonable for MetLife to make this a requirement to qualify for benefits. It is simply bad policy.

CONCLUSION

The Eighth Circuit has not made the ERISA disability landscape any clearer by clouding the issue as to when, why and how an objective evidence requirement can be implied into a policy when it does not exist. They do nothing to explain why it is ok for a plan administrator to arbitrarily add requirements without adequately giving a claimant/participant notice and/or time to respond to the new requirement. The Eighth Circuit's decision is contradicted by their subsequent decisions and needs to be clarified for all circuits.

For the foregoing reasons, Linda Pralutsky respectfully requests that the Court grant the petition for a writ of certiorari and reverse the decision of the United States Court of Appeals for the Eighth Circuit.

Respectfully Submitted,

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UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Linda Pralutsky,

Plaintiff,

v.

Civil No. 03-4389 (RHK/AJB)

MEMORANDUM OPINION AND ORDER

Metropolitan Life Insurance Company,

Defendant.

William L Marshall, Babcock, Neilson, Mannella, LaFleur & Klint, Anoka, Minnesota, for Plaintiff.

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Introduction

Like chronic fatigue syndrome, fibromyalgia "pose[s] significant problems for disability plan administrators?' Wilkins v. Hartford Life and Acc. Ins. Co., 299 F.3d 945

947 (8th Cir. 2002). After Metropolitan Life Insurance Company ("MetLife") denied Linda Pralutsky's claim for fibromyalgia-related disability, Pralutsky filed suit alleging that MetLife breached its fiduciary duty under the Employee Retirement Income Security Act of 1974 ("ERISA"). Each side has now moved for summary judgment. For the reasons set forth below, the Court will grant Pralutsky's motion and deny MetLife's motion with regard to the ERISA claim.[1]

Background

I. Introduction

Fibromyalgia is "a type of muscular or soft-tissue rheumatism that affects principally muscles and their attachment to bones." Lang v. Long-Term Disability Plan of Sponsor Applied Remote Tech. Inc., 125 F.3d 794, 796 (9th Cir. 1997). Also known as fibrositis, fibromyalgia is

> a common, but elusive and mysterious disease, much like chronic fatigue syndrome, with which it shares a number of features. Its cause or causes are unknown,

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[1] Pralutsky has also alleged breach of contract under state law. As Pralutsky tacitly now acknowledges, however, that claim is clearly preempted by ERISA. See, e.g., Kuhl v. Lincoln Nat'l Health Plan, 999 F.2d 298, 302-02 (8th Cir. 1993); see also 29 U.S.C. § 1144(a) (specifically preempting state laws that "relate to... any employee benefit plan"). The Court will therefore grant MetLife's motion to dismiss the breach of contract claim.

> there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective. There are no laboratory tests for the presence or severity of fibromyalgia.

Sarehet v. Chater, 78 F.3d 305, 306-07 (7th Cir. 1996).

> People with fibromyalgia have generalized pain, achiness, and stiffness all over their bodies ....The other main characteristic of fibromyalgia is chronic fatigue, probably related to disturbed sleep patterns. Sufferers often complain of waking up as tired as they were when they went to sleep, having continued fatigue throughout the day.

Morgan v. UNUM Life Ins. Co., 2002 WL 31095391 at *1 n.1 (D. Minn. Sept. 16, 2002) (Davis, J.) (quoting Simeon Margolis, M.D., Ph.D. & John A Flynn, M.D., The Johns Hopkins White Papers 89 (1995). "It is often difficult to diagnose fibromyalgia, an '[o]ften people with fibmmyalgia have undergone many tests and have seen many different specialists while in search of an answer.'" Lang, 125 F.3d at 796 (quoting "Fibromyalgia," Arthritis Foundation Pamphlet at 7 (1992)).

II. Pralutsky's Disability Claim

From 2000 to 2001, Pralutsky worked as a health unit coordinator at the Woodwinds Health Campus. (Mohs Aft. Ex. A at AR 62, 90.) Her duties included "[g]reeting and assisting visitors" and "carrying out all unit/clerical and

receptionist activities (i.e., answering phones, filing, maintaining bulletin boards, dislributing mail, etc.)" in the cardiopulmonary department. (Id. at AR 90.) She was paid $13.50 an hour and worked a 40-hour week. (Id. at AR 4.)

While at work in January 2001, Pralutsky felt pains in her chest and saw black spots in front of her eyes. (Id: at AR 42.) She was admitted to the intensive care unit at Woodwinds. (Id: at AR 42, 24.) Medical evaluations, however, came back negative, and she was released after four days. (Id. at AR 42, 7.) On July 31, 2001, Pralutsky began suffering these symptoms again and was readmitted for three days. (Id.)

Following the second hospitalization, Dr. Omar Tveten, Pralutsky's primary care physician, found that "weakness & pain" resulting from an as-yet undiagnosed illness rendered her "unable to do [her] duties" at Woodwinds. (Id. at AR 024.) He submitted a disability claim form to MetLife, Pralutsky's disability insurance provider. (Id.) He also sent the following note:

> Linda Pralutsky has been, and continues to be, disabled since July 31, 2001. She has seen a number of specialists, but as yet there has been no definitive diagnosis but her condition is such that she is unable to work

(Id. at AR 33.) He submitted a similar note the following week, reiterating that Pralutsky's inability to work stemmed from "recurrent pain, migratory in nature, and feelings of extreme weakness." (Id. at AR 37.) Dr. Tveten noted that although "[s]he starts the day with enthusiasm," after two hours she could not "force herself' any longer. (Id.) "She has seen a number of consultants but as of this moment no definitive diagnosis has been made." (Id).

On October 9, 2001, Pralusky saw Dr. Charles Ormiston, a neurologist to whom she had been referred by Dr. Tveten. (Id. at AR 42.) Dr. Ormiston also noted her substantial pain and fatigue:

> The pain is first in the legs and as that settles then she might get some pain in her arms as well and then will feel totally exhausted. She is better lying on her back than on her side. The pain seems to start in her hips and work down her legs. It is worse at night. There are times when she wakes up feeling totally exhausted. Other times when she can have a few hours feeling [okay] before this comes on. No days without pain for a long time now.

(Id:) After performing an examination and reviewing the results of her cat scan, Dr. Omiston concluded that she "best fit in a chronic fatigue or fibromyalgia category." (Id. at AR 43.) He submitted a disability form for MetLife, filling in the diagnosis code for fibromyalgia and noting her "severe

fatigability and lower ext[remity] pain." (Id. at AR 44.) After seeing Pralutsky several more times over the next month---and ruling out multiple sclerosis--Dr. Omiston confirmed the diagnosis of fibromyaigia, although he still "could not be sure that there is not an element of chronic fatigue syndrome." (Id. at AR 66.)

On December 11, 2001, MetLife denied Pralutsky's claim for disability benefits. (Id. at AR 75-76.) In the denial letter, the Plan Administrator reviewed Pralutsky's recent medical history and noted her "subjective reports of chest pain, dizziness and weakness in arms and legs." (Id.) The Plan Administrator noted that Dr. Tveten had "indicated [her] inability to work" due to those symptoms, and that "Dr. Ormiston felt you fit best into the category of fibromyalgia diagnosis." (Id.) Nevertheless, the Plan Administrator found that benefits must be denied. (Id.)

> We are unable to substantiate disability so severe to preclude you from returning to your own occupation on a full time basis throughout the elimination period and beyond. Medical documentation does not support severity of diagnosis for fibromyalgia nor does it support that you are aggressively treating and under appropriate care for said diagnosis. Therefore, benefits are denied.

(Id.) The letter closes by informing Pralutsky of her rights to appeal and submit additional medical and vocational information. (Id.)

On January 28, 2002, Pralutsky filed her notice of appeal. (Id. at AR 82.) She submitted her job description, as well as another letter from Dr. Tveten. (Id. at AR 89, 86.) That letter reads, in pertinent part,

> Linda continues to be totally disabled. Presently, the working diagnosis is fibromyalgia but there are elements of chronic fatigue syndrome as well. There are days she has so much pain it is difficult to even get out of bed. On a good day, she may function for 2 hrs but then becomes utterly fatigued & has to lie down. For someone who in the past has held down 2 full time jobs, this condition is extremely frustrating. [Her] neurologist, C. Ormiston, agrees there are very poor treatments for this condition. Antidepressants have been tried but [with a] poor response. Anti-inflammatories have been tried but [with a] poor response. It is hoped that time will lessen her symptoms but as of this time she remains totally disabled.

(Id: at AR 86.)

On appeal, MetLife submitted Pralutsky's file to "Elite Physicians," a division of Network Medical Review Co., Ltd. Id. at AR 98.) "Elite Physicians" describes itself as a "Provider[] of Evidence-Based Medical Reports." (Id.) MetLife asked the reviewing physician to define Pralutsky's

current level of functionality. (Id). at AR 93.) In addition, MetLife posed two specific questions: (1) "Is the employee's self reported functional ability substantiated by the cl0inical documentation," and (2) "Is the claimant's diagnosis supported by clinical objective findings?" (Id.)

Pralutsky's claim was reviewed by Dr. Chih-Hao Chou, a board-certified internist and rheumatologist. (Id). at AR 101.) After reviewing Pralutsky's medical history, Dr. Chou provided his analysis:

> The history of generalized pain from the legs to the arms and the associated symptoms of fatigue, insomnia, and depression, is consistent with the diagnosis of fibromyalgia. Ms. Pralutsky has undergone an extensive work-up and no definite pathology or abnormality was found to explain her symptom complex. Even though there is no documentation of the typical multiple tender points (more than 11 out of 18 fibromyalgia tender points), the diagnosis of fibromyalgia is supported, based on the description of her symptoms.

(Id.) at AR 99.) While Dr. Chou concluded that the diagnosis of chronic fatigue syndrome was not supported, he did find that Pralutsky was receiving "appropriate and regular medical care at this time." (Id. atAR 100.)

Dr. Chou acknowledged Pralutsky's "significant subjective pain and fatigue." (Id.) He found, however, that her impairment was "mild" based on the absence of any

"objective medical findings to support a more significant impairment." (Id.) He concluded that Pralutsky could therefore perform sedentary work. (Id.) "The subjective pain and fatigue are consistent with fibromyalgia; however, there is no objective abnormal finding.., to preclude her from performing any type of occupation." (Id.)

On April 11, 2002, MetLife affirmed its denial of Pralutsky's disability benefits.

The plan administrator explained his rationale:

> Upon completion of a thorough file review of all medical evidence in your claim file, it has been summarized that you have self reported significant functional inability to work secondary to your pain and fatigue. This is without substan[t]iation from the medical records B[e]sides self reported complaints, the[r]e [are] essentially no objective medical findings to support the pathology in the musculoske[le]tal or neurological systems. As your Own Occupation[] falls within the sedentary type of work, you are able to perform your current work.

(Id.) According to the letter, MetLife's original decision to deny benefits was "appropriate, and remains the same." (Id.)

On July 7, 2003, Pralutsky filed suit.

III. The Disability Plan

Under the MetLife plan in which Pralutsky was a participant (the Plan"), disability is defined as follows:

"Disabled" or "Disability" means that, due to Sickness, pregnancy or accidental injury, you are receiving Appropriate Care and Treatment from a Doctor on a continuing basis; and

1. During the first 24 months, including your Elimination Period, you are unable to earn more than 80% of your Predisability Earnings or Indexed Predisability Earnings at your Own Occupation for any employer in your Local Economy; or

2. after the 24 month period, you are unable to earn more than 80% of your Indexed Predisability Earnings from any employer in your Local Economy at any gainful occupation for which you are reasonably qualified taking into account your training, education, experience and Predisability Earnings

(Id.. at AR 155-156.) The "Elimination Period" is 90 days of continuous disability. (AR 151.)

To qualify as disabled, the claimant must have been receiving "appropriate care and treatment." (Id. at AR 155 (capitalization omitted).) Under the Plan, appropriate care and treatment is medical care that meets the following criteria:

1. it is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;
2. it is necessary to meet your basic health needs and is of demonstrable medical value;

3. it is consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research and health care coverage organizations and governmental agencies;
4. it is consistent with the diagnosis of your condition; and
5. its purpose is maximizing your medical improvement.

(Id: at AR 156.)

The Plan also requires that claimants provide "documented proof of...Disability."

(Id. at AR 166.) Proof" includes, but is not limited to,"

1. the date your Disability started;
2. the cause of your Disability; and
3. the prognosis of your Disability.

(Id. at AR 166-67.) In addition, claimants are "required to provide signed authorization for us to obtain and release medical and financial information, and any other items we may reasonably require in support of [the] Disability?'

(Id.. at AR 167.)

Finally, the Plan provides MetLife with the discretionary authority to determine benefits:

> In carrying out their respective responsibilities under he Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in

> accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

(Id: at AR 174.)

Standard of Decision

Summary judgment is proper if, drawing all reasonable inferences favorable to the non-moving party, there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249-50 (1986). The moving party bears the burden of showing that the material facts in the case are undisputed. See. Celotex, 477 U.S. at 322; Mems v. City of St. Paul, Dep't of Fire & Safety Servs., 224 F.3d 735, 738 (Sth Cir. 2000). The court must view the evidence, and the inferences that may be reasonably drawn from it, in the light most favorable to the nonmoving party. See Graves v. Arkansas Dep't of Fin. & Admin., 229 F.3d 721,723 (8th Cir. 2000); Calvit v. Minneapolis Pub. Schs., 122 F.3d 1112, 1116 (8th Cir. 1997). The nonmoving party may not rest on mere allegations or denials, but must show through the

presentation of admissible evidence that specific facts exist creating a genuine issue for trial. See Anderson, 477 U.S. at 256; Krenik v. County of Le Sueur, 47 F.3d 953,957 (8th Cir. 1995).

Analysis

I. ERISA Standard of Review

An ERISA plan participant may bring a civil suit "to recover benefits due to him under the terms of his plan, to enforce his fights under the terms of the plan, or to clarify his fights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Where, as here, a plan gives the administrator "discretionary authority to determine eligibility for benefits," the Court generally reviews the administrator's decision for abuse of discretion. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). This deferential standard stems from courts' hesitancy to interfere with the administration of benefits plans. Layes v. Mead Corp., 132 F.3d 1246, 1250 (8th Cir. 1998). Courts will, however, apply a less deferential standard of review to a plan administrator's decision when plaintiff presents "material, probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of

the plan administrator's fiduciary duty to her?' Woo v. Deluxe Corp., 144 F.3d 1157, 1160 (8th Cir. 1998).

Pralutsky contends that MetLife committed a serious procedural irregularity by refusing to consider the subjective evidence she submitted as legally sufficient evidence of disability. MetLife asserts that it was entirely proper for the Plan Administrator to deny Pralutsky's claim based on a lack of objective evidence. This poses a threshold question for the Court. If it was proper for MetLife to require Pralutsky to submit objective medical evidence, then it correctly processed her claim and the appropriate standard of review is abuse of discretion. If, however, MetLife was not entitled to deny her claim based on a lack of objective evidence, then it applied an arbitrary standard to her submissions. Because failing to credit her subjective evidence would constitute a serious procedural irregularity a less deferential standard would be appropriate.

A. Subjective and Objective Medical Evidence

To determine whether MetLife could properly deny Pralutsky's claim based on a lack of objective evidence, the Court must first answer two questions. First, whether, as MetLife suggests, it was reasonable as a matter of law for the Plan Administrator to require such evidence. Second, if 'the requirement was not per se reasonable, whether the Plan

Administrator was nonetheless entitled to do so under the terms of the Plan.

1. Per Se Reasonable

MetLife argues that "[i]t is not unreasonable for administrators to base disability decisions on the presence or absence of objective evidence." (Def.'s Mem. in Supp Summ. J. at 17.) For this proposition, MetLife cites the Eighth Circuit's recent holding in McGee v. Reliance Standard Life Ins: Co.., 360 F.3d 921 (8th Cir. 2004). McGee, however, is not the Eighth Circuit's only utterance on this subject in the ERISA context, and it is worth taking a detailed look at these recent holdings to determine whether the Eighth Circuit has established a blanket rule on objective medical evidence in ERISA cases.[2]

The Eighth Circuit fast grappled authoritatively with subjective-versus-objective medical evidence in ERISA cases in House v. Paul Revere Life Insurance Co., 241 F.3d 1045 (8th Cir. 2001). In House., the defendant insurer

[2] Each of the cases discussed below is a panel decision; the Eighth Circuit has not taken the question of objective medical evidence en bane. While the en banc court may overrule a previous panel decision, one panel of the Eighth Circuit is not at liberty to overrule another. See, e.g., Kostelec v. State Farm Fire & Cas. Co.., 64 F.3d 1220, 1228 n.8 (8th Cir. 1995).

denied plaintiff's long-term disability benefits on the ground that plaintiff had failed to provide "any objective medical findings [or] test data" to support his disability claim. Id. at 1047. In reversing the district court's grant of summary judgment for the insurer, the court applied an abuse-of-discretion standard and held that the plaintiff's documentation was sufficient. In so holding, the court stated:

> even if the exhaustive supporting documents [the doctor] submitted could be dismissed as subjective, nothing in the terms of the plan support[s] [the insurer's] demand for "objective medical evidence."

Id.. at 1048. House thus directs the Court to consult the plan itself to determine whether and under what circumstances plan administrator may require objective medical evidence.

The Eighth Circuit dealt again with subjective medical evidence in Walke v. Group Long Term Disability Ins., 256 F.3d 835 (8th Cir. 2001). The insured sued after the plan administrator denied a work-related stress claim on the ground that "[p]erceived stress is a subjective and unquantifiable factor which cannot be correlated with any objective evidence." Id.. at 838. In overturning this decision, the court, applying de novo review, noted:

> In its notice terminating benefits, [the insurer] explained that "stress is a subjective and unquantifiable factor which cannot be correlated" with the objective medical evidence needed to establish total disability. But an inability to cope with stress can disable a person from performing his or her regular occupation, even if the person can still perform other work.... Thus, that [plaintiff's] disability is stress-related does not preclude him from recovering plan benefits.

Id. at 841.

More ambiguous with regard to subjective and objective medical evidence is the Eighth Circuit's holding in Coker v. Metropolitan Life Ins. Co., 281 F.3d 793 (8th Cir. 2002). In Coker, the plan administrator denied a claim for long-term disability based on complications relating to diabetes. Applying an abuse-of-discretion standard, the court affirmed the district court's decision granting summary judgment in favor of the insurer.

> Upon review of the records submitted by all three physicians, MetLife rejected Coker's disability claim as unsupported by objective medical evidence. Although reasonable physicians could disagree on the extent of Coker's disability, MetLife's denial of benefits is not unreasonable. Under the deferential review accorded to plan administrator's denial of benefits, a reasonable conclusion by MetLife provide us with a sufficient basis to affirm the district court's grant of summary judgment.

Id. at 799. This language makes no mention of the plan language in justifying the demand for objective medical evidence. However, it also does not explicitly set forth a blanket rule regarding such evidence[3] Coker cites neither House nor Walke.

Finally, the Eighth Circuit most recently dealt with objective medical evidence in McGee, 360 F.3d 921. McGee filed a claim for long-term disability benefits based on "major affective disorder, anxiety, and various physical pains." Id. at 923. The claim was denied, Id. at 924. In

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[3] Six months after Coker, the Eighth Circuit dealt with the denial of a chronic fatigue syndrome claim in Wilkins v. Hartford Life and Ace. Ins. Co., 299 F.3d 945 (8th Cir. 2002). While deciding that the claim was time-barred, the court noted in dicta that the claim was analogous to one resolved five years earlier by the Third Circuit: "The record in this case is not unlike that in Mitchell v. Eastman Kodak Co., 113 F.3d 433, 441-43 (3d Cir. 1997), where the Third Circuit concluded an ERISA plan administrator abused its discretion in denying benefits. Here, the reasons given by Hartford personnel for denying the claim are much like the reasons criticized by the court in Mitchell, primarily the lack of 'objective medical evidence' of CFS." Id. at 947 n.1; see also Mitchell, 113 F.3d at 442 ("Because the disease, although universally recognized as a severe disability, has no known etiology, it would defeat the legitimate expectations of plan participants in the Kodak Plan to require those with CFS to make a showing of clinical evidence of such etiology" (internal citation and quotation omitted).

reversing the district court's grant of summary judgment for the plaintiff, the court applied an abuse-of-discretion standard and held that absence of objective evidence provided a sufficient basis for the denial. The court stated:

> We hold that the company's decision was based on substantial evidence. The medical records of [the psychologist] and [the primary care physician] were inconsistent, and neither provided reliable objective evidence of testing or other proof to support the finding of a long-term disability. It is not unreasonable for a plan administrator to deny benefits based upon a lack of objective evidence. Coker v. Metro Life Ins. Co., 281 F.3d 793,799 (8th Cir. 2002).

Id. at 924-25. In so holding, the court read Coker for the proposition that plan administrators may reasonably deny benefits based on a lack of objective evidence. Like Coker, McGee. cites neither House nor Walke.[4]

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[4] One month prior to McGee, the Eighth Circuit issued an unpublished opinion taking the opposite approach. See Collins v. Continental Cas. Co., 87 Fed. Appx. 605 (8th Cir. 2004); see also 8th Cir. Rule 28A(i) (allowing for the citation of unpublished opinions "if the opinion has persuasive value on a material issue and no published opinion of this or another court would serve as well."). Again applying a deferential standard, the court held that it was an abuse of discretion for the plan administrator to ignore the claimant's self-reported symptoms of chronic and disabling pain. "[I]t

Examining these cases together, it is clear that the Eighth Circuit takes no single approach to subjective and objective evidence in the context of ERISA. Rather, the court appears to engage in a case-specific analysis with regard to the particular claims and policy language before it.

In practice, its approach is not unlike that of the First Circuit, which has noted with regard to objective medical evidence:

> [C]ases such as these are by nature very fact-oriented. We fully recognize that laboratory tests or similar diagnostic procedures will not always be necessary to substantiate a Claim of disability, as certain disabling conditions are not susceptible to such objective evaluations.

Brigham v. Sun Life of Canada, 317 F.3d 72, 84 (lst Cir. 2003). While McGee cites Coker for the proposition that plan administrators may reasonably require the claimant to submit objective evidence, it does not state that plan administrators may always do so. Indeed, if Coker. and McGee so held, they would directly conflict with

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appears the plan administrator simply refused to consider her subjective complaints as legally sufficient evidence. However, *a plan administrator may not deny benefits simply because the only evidence of a disabling condition is subjective evidence.*" Collins, 87 Fed. Appx. at 607 (emphasis added).

House and Walke. In this Court's view, however, no such conflict exists; the Eighth Circuit has not established a per se role regarding objective medical evidence in ERISA cases, but rather a consistent, fact- specific approach. [5]

2. The Terms of the Plan

In the absence of a blanket rule, however, the Plan Administrator may still require objective medical evidence if permitted by the terms of the Plan. House 241 F.3d at 1048. An ERISA plan is a "creature[] of contract law," Jenkins v. Local 705 Int'l Bhd. of Teamsters Pension Plan, 713 F.2d 247, 252 (7th cir. 1983), and as long as its provisions are consistent with the governing statute, the rights and responsibilities of each party are bounded by the terms of the agreement. In that spirit, the Court examines the language of the Plan using "ordinary rules of construction." DeGeare V: Alpha Portland Indus., 837 F.2d 812, 816 (8th Cir. 1988). The Court accords plainly stated terms "their ordinary, and not specialized, meanings." Brewer v. Lincoln Nat'l Life Ins. Co., 921 F.2d !50, 154 (8th Cir. 1990).

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[5] Were such a conflict to exist, the Court would be "free to cho[o]se which line of cases to follow," United States v. Slicer, 361 F.3d 1085, 1087 n.1 (8th Cir. 2004), and would follow the approach set forth by House, not simply because it is first, see Kostelec, 64 F.3d at 1228 n.8, but because it represents the better rule of law.

The Plan provides two plausible bases for requiring objective medical evidence. The first is the Plan provision requiring "documented proof of....Disability." (Mohs Aft. Ex, A at AR 166.) This proof "includes, but is not limited to,"

1. the date your Disability started;
2. the cause of your Disability; and
3. the prognosis of your Disability.

(Id.) As part of the claims process, the claimant must "provide signed authorization for us to obtain and release medical and financial information, and any other items we may reasonably require." (Id. at AR 167.) This information includes "proof of continuing Disability." Id.) Should the claimant "not provide satisfactory documentation within 60 days of the date we ask for it, [the] claim may be denied." (Id.)

This language does not allow the Plan Administrator to require objective medical evidence. The Plan requires "proof," a term that is undefined in the policy. The English Dictionary defines "proof' as "evidence sufficient (or contributing) to establish a fact or produce belief in the certainty of something." See "Proof, n.l," Oxford English Dictionary Online, available at <http://dictionary.oed.com/cgi/entry/00190047>; see also

Fed. R. Evid. 201(b). This definition, which generally accords with the plain-meaning of the term, makes no distinction between subjective and objective evidence. Rather, it encompasses all types of evidence that contribute to establishing a fact or eliciting belief. Either subjective or objective evidence will do.

The second potential basis for the Plan Administrator to require objective medical evidence is the Plan's generalized grant of discretion. As stated in this provision,

> In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for any entitlement to Plan benefits in accordance with the terms of the Plan.

(Mohs Aft. Ex. A at AR 174.) This provision instructs that interpretations made pursuant to that authority "shall be given full force and effect, unless it can be shown that the interpretation was arbitrary and capricious."[6] (Id.)

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[6] The Plan also provides that documents submitted in support of the claim be "subject to [MetLife's] satisfaction?' (Mohs Aft. Ex. A at AR 153.) The Eighth Circuit has interpreted this language as granting discretion coextensive with the grant of discretion described above. See Walke, 256 F.3d at 840; Ferrari v. Teachers Ins. and Anuity Ass'n, 278 F.3d 801,806 (8th Cir. 2002); see also Kinstler v. First Reliance

The generalized grant of discretion does not provide an adequate basis for requiring objective evidence. Were this provision sufficient, the Eighth Circuit would likely have upheld the plan administrator's decisions in House and Collins; rather, in each case, one precedential and one persuasive, the court overturned a denial of benefits made under similar discretionary authority where the decision was motivated by the subjective character of the claimant's evidence. See House, 241:F.3dat-1048; Collins, 87 Fed: Appx. at 606. Indeed, House explicitly states that "*nothing* in the terms of the plan support [the insurer's] demand for objective medical evidence.'" House, 241 F.3d at 1048 (emphasis added). Because the plan administrator's discretionary authority can only stem from "the terms of the plan," id; see also Firestone Tire, 489 U.S. at 115, that "nothing" includes the grant of discretion.

Standard Life Ins. Co., 181 F.3d 243, 252 (2d Cir. 1999) ("Every plan that is administered requires submission of proof that will 'satisfy' the administrator .... Thus, saying that proof must be satisfactory 'to the administrator' merely states the obvious point that the administrator is the decision-maker, at least in the first instance.") Put another way, the "satisfaction" language does allow MetLife to require *more* from the evidence than its discretion already allows.

ERISA plans are flee to contract for whatever type of evidence they choose. The word "proof' is sufficiently broad to encompass either subjective or objective evidence, and the Court will therefore not permit the Plan Administrator to make that distinction post hoc. To allow such an untimely redrafting of the Plan would be to allow MetLife to gain an unbargained-for benefit so as to "defeat the legitimate expectations of [Plan] participants." Mitchell v. Eastman Kodak Co., 113 F.3d 433, 443 (3d Cir. 1997). This is especially so with fibromyalgia, where the disease is "difficult to diagnose" and the main disabling symptoms--such as "fatigue, sleep disturbances, lack of concentration, changes in mood or thinking; anxiety and depression"--- are subjective. Lang. 125 F.3dat 796. The Court therefore determines that the generalized grant of discretion did not provide a basis for the Plan Administrator to require objective medical evidence. Indeed, in the context of this disease and this Plan, it was arbitrary and capricious to do so.

B. The Effect on the Standard of Review

This conclusion has a substantial effect on the standard of review. The Plan Administrator's central rationale for upho!ding the denial of Pralutsky's claim on appeal was that there were "essentially no objective medical

findings to support the pathology." (Mobs Aft. Ex. A at AR 174.) In fact, the Plan Administrator specifically instructed the outside medical consultant to determine whether her condition was "supported by clinical objective findings." (Id. at AR 93.) Justified by neither the law nor the Plan, the use of this standard means that an "arbitrary decision," Layes , 132 F.3d at 1250, was "reached without reflection and judgment," Buttram v. Central States, S.E. & S.W. Areas Health & Welfare Fund , 76 F.3d 896, 900 (8th Cir. 1996). It therefore constitutes a serious procedural irregularity. Moreover, because this error was linked to--and, in fact, lay at the heart of--the decision to deny benefits, less deferential review is appropriate.[7]

II. Sliding-Scale Review

Having determined that Pralutsky has "traverse[d] the Woo gateway," Schatz v. Mutual of Omaha Ins. Co., 220

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[7]Although abandoned on appeal, the original grounds for the denial of claim also demonstrate a misapplication of the plan language. The Plan Administrator initially denied coverage because "[m]edical documentation does not support *severity* of diagnosis for fibromyalgia." (Mohs Aft. Ex. A atAR 76 (emphasis added).) Not only, however, does the Plan not contain a "severity" requirement, but, as the Seventh Circuit has recognized,"[t]here are no laboratory tests for the presence or severity of fibromyalgia." Sarchet, 78 F.3d at 306-07 (emphasis added).

F.3d 944, 949 (8th Cir. 2000), the Court will review MetLife's denial of benefits under a "sliding scale" standard. Under this standard, "the evidence supporting the plan administrator's decision must increase in proportion to the seriousness of the conflict or procedural irregularity." Woo, 144 F.3d at 1162: Because the procedural irregularity was egregious--indeed, it so pervaded the analysis as to make the task of separating the error from the substantive decision nearly impossible--the Court will "require that the record contain substantial evidence bordering on a preponderance" to support the denial of benefits. Id:

To qualify as disabled under the policy, Pralutsky was required to demonstrate that she was both (1) receiving appropriate care, and (2) had suffered a substantial reduction in her earning capacity due to illness. Under the Plan, "appropriate care" is defined as medical care that meets the following criteria:

1. it is received from a Doctor whose medical training and clinical experience are suitable for treating your Disability;
2. it is necessary to meet your basic health needs and is of demonstrable medical value;
3. it is consistent in type, frequency and duration of treatment with relevant guidelines of national
medical, research and healthcare coverage organizations and governmental agencies;

4. it is consistent with the diagnosis of your condition; an
5. its purpose is maximizing your medical improvement.

(Mobs Ex. A at AR 156.) The Plan also required Pralutsky to demonstrate that, "due to sickness, pregnancy or accidental injury... [she was] unable to earn more than 80% of [her] Predisability Earnings or Indexed Predisability Earnings at [her] Own Occupation for any employer in [her] Local Economy .... " (Id. at AR 155.)[8]

Under these requirements, the record does not contain substantial evidence--whether bordering on a preponderance or not--to justify the denial of benefits. The

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[8] As discussed above, the Plan requires claimants to provide "proof" of disability. (Mobs Aft. Ex. A at AR 166.) Proof includes the date, cause, and prognosis of the disability. (Id.) Here, Pralutsky submitted evidence that "weakness & pain" resulting from an illness had rendered her "unable to do [her] duties" since July 31, 2001. (Id.. at AR 24, AR 25, AR 33.) She also submitted evidence that her disability was caused by fibromyalgia. (Id. at AR 44, AR 86.) Finally, she submitted evidence regarding her prognosis, including the opinion of her doctors that, "while time [might] lessen her symptoms," there "are very poor treatments for [fibromyalgia]." (Id. at AR 86.) This evidence, entirely unrebutted, satisfies the Plan's "proof' requirement.

Plan Administrator initially denied Pralutsky's claim because, in part, she was not "aggressively treating" her condition. (Id. at AR 76.) The Plan, however, does not require that treatment be "aggressive"; it requires that it be "appropriate," in that it be from a suitable doctor necessary to meet health needs, consistent with medical guidelines, and for the purpose of maximizing improvement MetLife, by not affirming the challenge to Pralutsky's care on appeal, has effectively conceded this point. (.See id. at AR 100.) Indeed, Dr. Chou, MetLife's own reviewing physician, stated that "[t]he records support that Ms. Pralusky is receiving appropriate and regular medical care at this time." Id.. at AR 100.) Given this statement--and the utter lack of evidence to the contrary--the Court finds that Pralutsky was receiving appropriate care as required by the Plan.

Pralutsky also demonstrated that, "due to sickness," she was unable to earn 80% of her pre-disability earnings at her occupation. According to the information before the Plan Administrator, Pralutsky doctors agreed that her illness "fit[] best :into [the] fibromyalgia category," although she displayed "elements of chronic fatigue syndrome as well." (ld. at AR 66, 86.) While MetLife's doctor, Dr. Chou, disagreed with chronic fatigue

syndrome diagnosis, he found that "the diagnosis of fibromyalgia is supported." (Id. at AR 99 (emphasis added).) As recounted by Dr. Ormiston, her neurologist, this disease caused Pralutsky significant pain and fatigue:

> The pain is perceived first in the legs and as that settles then she might get some pain in her arms as well then will feel totally exhausted.... The pain seems to start in her hips and work down her legs. It is worse at night. There are times when she wakes up feeling totally exhausted. Other times when she can have a few hours feeling [okay] before this comes on. No days without for a long time now.

(Id. at AR 42.) According to Dr. Chou, this "subjective pain and fatigue [is] consistent with fibromyalgia." Id. 100.)

Because of these subjective symptoms, Pralutsky was unable to perform--and, *a fortiori,* earn income at---her occupation. Dr. Tveten, Pralutsky's primary care physician, found her unable to work due to "recurrent pain, migratory in nature, and feelings of extreme weakness." (Id.. at AR 37.) Dr. Ormiston, while initially optimistic she would improve, would not advise her to return to work because "[s]he simply can't"; indeed, he found that Pralutsky

could not sit, stand, or walk for even a single hour of the day.[9] Even Dr. Chou found "significant [self-reported] functional inability to work." (Id.) This evidence demonstrates a substantial, almost total, reduction in Pralutsky's earning capacity.

While Dr. Chou concluded that Pralutsky's impairment was "mild" and that she would be "able to perform at least sedentary type of work", the value of this opinion is erased by his insistence on objective medical

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[9] Dr. Chou---considering only "the clinical evaluations, *objective* medical evidence and diagnostic test results"--concluded that Pralutsky could stand or walk for up to an hour a day during a typical work schedule. (Id. at AR 95, 94 (emphasis added).) Although he concluded that Pralutsky was therefore able to perform "sedentary type of work" (id. at AR100), this conclusion is "at odds with the generally recognized definition of such work," which states that "sedentary work generally involves up to *two hours of standing or walking'"* during an eight-hour work day, Connors v. Connecticut Gen. Life Ins. Co., , 272 F.3d 127, 136 (8th Cir. 2001) (applying social security definition that accords with generally recognized definition in the context of ERISA claim for chronic fatigue syndrome) (internal quotations omitted). Pralutsky's job description suggests that her job required at least that. (Mohs Aff. Ex. A at AR 89-90.)

evidence to justify her disability. As Judge Posner noted, with regard to **the same doctor** reviewing a claim for **the same condition.**

> [T]he gravest problem with Dr. Chou's report is the weight he places on the difference between subjective and objective evidence of pain. Pain often and in the case of fibromyalgia cannot be detected by laboratory tests. The disease itself can be diagnosed more or less objectively..., but the amount of pain and fatigue that a particular case of it produces cannot be. It is "subjective"...and Dr. Chou seems to believe, erroneously because it would mean that fibromyalgia could never be shown to be totally disabling,. . . hat is because it is subjective, [plaintiff] is not disabled.

Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3d 914, 919 (7th Cir. 2003) (Posner, J.) (finding that insurer abused its discretion by denying benefits for fibromyalgia claim based on a lack of objective evidence). Almost to the letter, Dr. Chou has repeated these same errors here. [10]

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[10] For instance, while finding "significant subjective pain and fatigue," Dr. Chou nonetheless concluded that Pralutsky's impairment was "mild" due to a lack of "objective medical findings to support more significant impairment." (Mohs Aff_ Ex. A at AR 100.)
Likewise, Dr. Chou found that "[t]he subjective pain and fatigue are consistent with fibromyalgia; however, there is no objective abnormal finding. . . . that would preclude her

Without the requirement of objective medical evidence, "[t]he record contains nothing more than scraps to offset the evidence presented" by Pralutsky. Id. While such a requirement may not be arbitrary and capricious in every instance, in the face of an "elusive and mysterious" disease like fibromyalgia whose "symptoms are entirely subjective," Sarchet, 78 F.3d at 306-07, it is arbitrary and capricious here. Accordingly, because the record does not contain substantial evidence to support the denial of benefits, the Court will grant Pralutsky's motion on her ERISA claim.[11]

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from performing any type of occupation." (Id.)

[11] As a final matter, MetLife has, during be briefing and oral argument for this motion, raised for the first time a number of additional bases for rejecting Pralutsky's claim. While the Court is tempted to explain in detail why each of these rationales is defective--and each *is* defective--it will not do so. Under ERISA, a denial of claim must be written "in a manner calculated to be understood by the claimant" and contain"[t]he specific reasons for the denial." 29 C.F.R. § 2560.503-1(g)(1)(i). In the Eighth Circuit, courts "are free to ignore ERISA plan interpretations that did not *actually furnish the basis* for a plan administrator's benefit decision" as communicated to the plan participant .Marolt v. Alliant Techsystems, Inc., 146 F.3d 617, 620 (8th Cir. 1998) (emphasis added) Because any other approach would allow ERISA claimants to be "sandbagged by after-the-fact plan

Conclusion

Based on the foregoing, and all of the files, records, and proceedings herein, **IT IS ORDERED**:

1. MetLife's Motion for Summary Judgment (Doc. No. 6) is **GRANTED IN PART;** to the extent Pralutsky alleges state law breach-of-contract, that claim is **DISMISSED WITH PREJUDICE**; and

2. Pralutsky's Motion for Summary Judgment (Doe. No. 7) is **GRANTED**;

   a) Pralutsky is awarded past-due long-term disability benefits and prejudgment interest;[12] and

   (b) MetLife shall reinstate Pralutsky in its long-term disability plan as a participant entitled to benefits trader the Plan.[13]

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interpretations devised for purposes of litigation," id, the Court will "not consider [MetLife' s] post hoc rationales." Conley v Pitney Bowes, 176 F.3d 1044, 1049 (8th Cir. 1999).

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Prejudgment interest is appropriate because (1) MetLife "has continued to have use use of th[e] money," (2) "the

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: May 3, 2004

s/Richard H.Kyle
RICHARD H. KYLE
United States District Judge

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exact amount of liability on the plan[] was never in doubt," and (3) "an award of prejudgment interest is necessary in order... [to] obtain "appropriate equitable relief."Dependahl v. Falstaff Brewing Corp., 653 F.2d 1208, 1218 (8th Cir. 1981) (quoting 29 U.S.C. § 1132(a)(3)(B)).

[13] Should Pralutsky move for attomeys' fees and costs pursuant to 29 U.S.C. § 1132(g), that motion must be made in accordance the time limits set forth in Local Rule 54.3 If filed, the motion shall be accompanied by a memorandum, affidavit, and supporting documents. The Court will provide Met.Life with an opportunity to respond.

United States Court of Appeals
FOR THE EIGHTH CIRCUIT

No. 04-2409

Linda Pralutsky, *
Appellee, *

Metropolitan Life Insurance Company, Appellant.

Appeal from the United States District Court for the District of Minnesota

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No. 04-3239

Linda Pralutsky, *
Appellee, *
V. *
Metropolitan Life Insurance *
Company, *
Appellant. *

Submitted: May 12, 2005
Filed: January 19, 2006

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both sides moved for summary judgment, the district court granted Pralutsky's motion and ordered MetLife to pay past-due benefits to Pralutsky and to reinstate her in the plan as a participant entitled to benefits. The court also awarded attorneys' fees to Pralutsky. MetLife appeals, and we reverse.

I.

In 2000, Linda Pralutsky was a full-time ,'health unit coordinator" at the Woodwinds Health Campus, where her duties included clerical and receptionist activities, such as answering phones, greeting visitors, filing, and distributing mail. In January 2001, Pralutsky began suffering from chest pain and leg weakness, and reported seeing spots in front of her eyes. She was hospitalized with these symptoms, but tests performed during her stay did not lead to a diagnosis. Although she reported gradual improvement after leaving the hospital, in July 2001, she began suffering the same symptoms again and was re-admitted for evaluation. Again, no diagnosis was made, but on July 31, 2001, Pralutsky ceased working. She applied to MetLife for long-term disability benefits in November 2001.

In support of her application for disability benefits, Pralutsky was required by MetLife's plan to provide "documented proof of [her] Disability," and "proof" was

defined to include the date disability started, the cause of disability, and the prognosis of the disability. (A.R. at 166). To meet this requirement, Pralutsky provided an Attending Physician Statement by her primary care physician, Omar Tveten, M. and a supplementary statement by a neurologist, Charles Ormiston, M.D. Both of these documents generally attested to Pralutsky's inability to work: Dr. Ormiston opined that she ,'simply can't" work,but that he was "hopeful that in 3-4 weeks she'll be better," and Dr. Tveten stated that she was "unable to do duties" and indicated that he had not advised her to return to work. (A.R. at 26, 44). Both documents also reported Pralutsky's subjective complaints of pain. Neither physician provided any lab results, office notes, or other clinical findings with the forms, although both forms requested copies of such materials.

In addition to the supplementary form, Dr. Ormiston wrote a letter to Dr. Tveten, which was provided to MetLife, describing Pralutsky's complaints and examination results. Dr. Ormiston described Pralutsky's pain as starting in her legs, then moving to her arms, or starting in her hips and moving down her legs. He reported that "Is]he is better lying on her back than on her side," that "[i]t is worse at night," and that she "wakes up feeling totally exhausted." (A.R. at

42). On examination, however, Dr. Ormiston reported that her cranial nerves were normal; motor strength, tone, and bulk were normal; reflexes were symmetric; and cerebellar, sensory, station, and gait testing were all normal, except that pain interfered with Pralutsky's ability to walk on her toes and heels. Testing to that point, including a bone scan and abdominal pelvic CT scan, was all negative. Dr. Ormiston opined that the symptoms "seem to fit best in a chronic fatigue or fibromyalgia category," but that he would do an MRI scan "to make sure we are not missing a demyelinating disease or similar problem." (A.R. at 43).

After the MRI, Dr. Ormiston wrote to Dr. Tveten again to inform him that the MR/ "showed one demyelinating lesion," which raised suspicions of multiple sclerosis, but that MRI scans of her cervical and thoracic spine were essentially negative. (A.R. at 64). He also noted a thyroid lesion, but left evaluation of that to Dr. Tveten. After a spinal fluid evaluation, Dr. Ormiston wrote to Dr. Tveten a third time and indicated that, with her "completely normal spinal fluid evaluation," he was of the opinion that Pralutsky did not have multiple sclerosis. He suggested that she might pursue a sleep study or further trials with medication, but believed that because there was

no "neurologic abnormality," he had nothing further to offer her as a neurologist. (A.R. at 66).

Pralutsky's claim was also supported by several handwritten notes from Dr. Tveten to MetLife indicating that Pralutsky was disabled and that she had seen specialists but had not yet been definitively diagnosed with a particular illness. Dr. Tveten also reported that Pralutsky suffered from"recurrent pain, migratory in nature" and "feelings of extreme Weakness," such that she could not "force herself any more than two hours out of the day. (A.R. at 37).

In addition to her doctors' opinions, Pralutsky submitted a form that she filled out independently, which reported "weakness, fatigue, pain, [and] severe headache," and stated that she had "about 2 hrs of energy" each day. (A.R. at 57-58). Pralutsky indicated that she was able to do some housework, but that "it might take [her] all day" to dust and vacuum, and that her children helped her run the household. (A.R.at 60). She indicated that she did not have sleeping problems, but also noted that head pain recently had prevented her from sleeping well. In two telephone conversations with representatives from MetLife, Pralutsky repeated her complaints of pain and weakness, and again noted that she needed assistance from her family in household chores. She also indicated that she "takes walks,"

and that she drove her children to and from school, and cooked when feeling energetic enough. Pralutsky Was not using over-the-counter medicine for her pain, was not taking anti-inflammatory drugs, and was not otherwise treating her symptoms.

MetLife's representative advised Pralutsky to seek a referral to a rheumatologist and to consider whether physical therapy or aqua therapy would be appropriate. After its conversations with Pralutsky, MetLife faxed a "Fibromyalgia Initial Functional Assessment Form" to Dr. Ormiston, seeking specific examination information about symptoms, severity, and treatment. MetLife also inquired about Pralutsky's treatment, whether she had reached her maximum medical improvement, and whether Dr. Ormiston believed she might return to work gradually. Dr. Ormiston did not answer those inquiries or return the assessment form.

After reviewing the information from Pralutsky and her doctors, MetLife denied Pralutsky's claim in a letter dated December 11, 2001. After summarizing the evidence that it had received, MetLife wrote that

> [w]e are unable to substantiate disability so severe to preclude you from returning to your own occupation on a full time basis throughout the elimination period and beyond. Medical documentation does not support

> severity of diagnosis for fibromyalgia nor does it support you are aggressively treating and under appropriate care for said diagnosis. Therefore, benefits are denied.

(A.R. at 76).

On January 28, 2002, Pralutsky wrote to MetLife indicating that she wished to appeal the denial of benefits, and MetLife responded that "in order to support your claim of disability, we will need treatment records from your treating physicians that indicate your current treating diagnosis, restrictions and limitations, and ongoing current treatment plans." MetLife also added that "your doctor must provide his clinical findings and rationale which supports your claim that you are functionally precluded from performing your own occupation for any employer." (A.R. at 83).

In response to this request for more information, Dr. Tveten submitted another handwritten opinion letter to MetLife, in which he again suggested that Pralutsky was suffering from pain and fatigue that left her "totally disabled." He indicated that the "working diagnosis" was fibromyalgia but that there were "elements of chronic fatigue syndrome," and that anti-depressants and anti-inflammatories had been tried

without success. (A.R. at 86). No other medical information or clinical reports were submitted.

MetLife sought an independent review of Pralutsky's entire file by a physician consultant, Chih-Hao Chou, M.D., Ph.D. Dr. Chou, a board-certified physician in Internal Medicine and Rheumatology, was asked to define Pralutsky's current level of functionality, to address whether her self-reported functional ability was sustained by clinical documentation, and to opine whether her diagnosis was supported by clinical objective findings.

Dr. Chou reviewed Pralutsky's file and responded that "[e]ven though there is no documentation of the typical multiple tender points (more than 11 out of 18 fibromyalgia tender points) the diagnosis of fibromyalgia is supported, based on the description of her symptoms and the exclusion of other diagnoses." (A.R. at 99). But in Dr. Chou's view, this diagnosis was insufficient to show that Pralutsky was totally disabled. Dr. Chou opined that she had only a "mild impairment," and that the record did not contain "any objective medical findings to support more significant impairment." (A.R. at 100). Therefore, Dr. Chou believed that Pralutsky should still be able to perform her current sedentary work. In addition, Dr. Chou noted that she was receiving "appropriate and regular" medical care, but that she

"has not exhausted all of her treatment options and she has not reached maximum medical improvement." *(Id.)*.

In a letter dated April 11, 2002, MetLife informed Pralutsky that after review, it was upholding the previous denial of benefits. MetLife said that Pralutsky had "self reported significant functional inability to work," but that this was "without substantiation from the medical records." (A.R. at 103). Aside from her self-reported complaints, MetLife found there were "essentially no objective medical findings to support the pathology in the musculosketal [sic] or neurological systems." *(Id.)*

Pralutsky then filed the instant action, alleging that MetLife breached its fiduciary duties under the Employee Retirement Income Security Act of 1974 ("ERISA").[14] The district court found that MetLife had committed an "egregious" procedural irregularity in denying benefits to Pralutsky, and therefore reviewed the denial of benefits without the deference normally accorded to a plan

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[14] Pralutsky also initially alleged that MetLife's denial of benefits was a breach of contract. This state law claim was dismissed with prejudice by the district court, and Pralutsky does not appeal the dismissal of this claim. *See Pralutsky v. Metro. Life Ins. Co.*, 316 F. Supp. 2d 840, 842 n.1 (D. Minn. 2004).

administrator. The court concluded that "substantial evidence bordering on a preponderance"--the heightened review standard it applied--did not support the denial of benefits, and ordered MetLife to pay benefits, including past-due benefits and prejudgment interest. After a motion by Pralutsky, the court also awarded attorneys' fees and costs to Pralutsky in the amount of $14,179.11.

II.

Under ERISA, a plan participant may bring a civil action to "recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Where the plan reserves discretionary authority to the plan administrator, we apply a deferential standard of review, considering whether the administrator abused its discretion. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111 (1989); King v. Hartford *Life & Accident Ins. Co.*, 414 F.3d 994, 998-99 (8th Cir. 2005) (en banc). We have said that this deferential standard is not applicable, however, if the claimant demonstrates that "a serious procedural irregularity existed" and caused a "serious breach" of the plan administrator's fiduciary duty to the claimant. *Buttram v. Cent. States, S.E. & S. W. Areas*

Health & Welfare Fund, 76 F.3d 896, 899-900 (8th Cir. 1996). We review *de novo* the district court's decision to grant summary judgment.

Pralutsky argues that MetLife committed a "serious procedural irregularity" in her case by insisting that she provide objective evidence of her disability. According to Pralutsky, this requirement was not justified by the plan's terms, and therefore indicates that the administrator's decision was arbitrary and not entitled to deference. The district court agreed, and required instead that the record contain "substantial evidence bordering on a preponderance" to support the denial of benefits. Pralutsky, 316 F. Supp. 2d at 851.

We disagree that MetLife's reliance on the absence of objective evidence for its denial of benefits constitutes a "serious procedural irregularity" that justifies abandoning the deference normally accorded an administrator's decision under ERISA. When we introduced this concept, we explained that under the common law of trusts, which is our guide in reviewing the benefits determinations of ERISA plan trustees, heightened scrutiny may apply "where the plan trustee labors under a conflict of interest, or where, in the exercise of his power, he acts dishonestly, or from an improper motive, or he fails to use judgment in reaching his

guide in reviewing the benefits determinations of ERISA plan trustees, heightened scrutiny may apply "where the plan trustee labors under a conflict of interest, or where, in the exercise of his power, he acts dishonestly, or from an improper motive, or he fails to use judgment in reaching his decision." *Buttrum,* 76 F.3d at 900 (internal citations omitted). When we speak of "procedural irregularity" in this context, therefore, we refer to the sorts of external factors that are sufficient under the common law of trusts to call for application of a less deferential standard of review. Before such heightened review applies, the claimant "must show (1) that a serious procedural irregularity existed, which (2) caused a serious breach of the plan trustee's fiduciary duty to the plan beneficiary." *Id.*

While the parties hotly contest whether the administrator's decision in this case was reasonable, we are not persuaded that the decision was made without reflection or judgment, such that it was "the product of an arbitrary decision or the administrator's whim." *Buttram,* 76 F.3d at 900; Restatement (Second) of Trusts § 187 cmt. h (1959). This is not a case where the plan trustee failed to inquire into the relevant circumstances at issue, or never offered a written decision that can be reviewed, or committed irregularities so severe that the court "has a total lack of faith

in the integrity of the decision making process." *Buttram*, 76 F.3d at 900. What we have here is a dispute over whether the administrator reasonably interpreted the plan to require objective medical evidence to prove the claimant's disability, and whether the record supports the administrator's exercise of judgment that benefits should be denied based on the evidence that was presented. The administrator's decision--whether right or wrong, reasonable or unreasonable--was not made "without knowledge of or inquiry into the relevant circumstances and merely as a result of [its] arbitrary decision or whim.," Restatement (Second) of Trusts § 187 cmt. h. The normal standard of review is thus appropriate.

Under that standard, we consider whether the administrator abused its discretion--that is, whether its interpretation of the plan was reasonable, and whether its decision was supported by substantial evidence. *King*, 414 F.3d at 999. We have said that in some circumstances a plan administrator's insistence on objective medical evidence can be unreasonable. In *House v. Paul Revere Life Insurance Co.*, 241 F.3d 1045 (8th Cir. 2001), we concluded that it was an abuse of discretion for a plan administrator to insist on "objective medical evidence" of heart disease, where the plan documents advised only that the administrator "may require medical exams or written

proof of *financial loss,*" and stipulated that if a medical exam was required, the administrator would pay for it. *Id.* at 1048 (emphasis added). There may be other cases in which objective evidence simply cannot be obtained, and it would be unreasonable for an administrator to demand the impossible. *See Brigham v. Sun Life of Can.*, 317 F.3d 72, 84 (lst Cir. 2003). And it may well be unreasonable for an administrator to expect a claimant to provide "objective evidence" if the administrator does not provide an adequate explanation of the information sought.

We have held elsewhere, however, that "[i]t is not unreasonable for a plan administrator to deny benefits based upon a lack of objective evidence," *McGee v. Reliance Standard Life Insurance Co.*, 360 F.3d 921,924-25 (8th Cir. 2004), and *House* does not state a universal rule that an administrator is precluded from insisting on objective medical evidence when it is appropriate under the terms of a plan and the circumstances of the case. *See also Hunt v. Metro. Life lns. Co.*, 425 E3d 489, 491 (8th Cir. 2005) (per curiam) (upholding a denial of benefits where objective medical evidence did not support claimed disability from restless leg syndrome and related problems); *Coker v. Metro. Life Ins. Co.*, 281 F.3d 793,799 (8th Cir. 2002) (finding denial of benefits not unreasonable where objective

medical evidence did not support claimant's contention that he was disabled by diabetes and syncopal episodes). The plan in this case states that the claimant must provide, at her own expense, "documented proof of [her] Disability," and that if the claimant does not provide "satisfactory documentation within 60 days after the date we ask for it," the claim may be denied. (A.R. at 166-67). The plan does not define what sort of "proof" or "documentation" is sufficient to establish a disability, and the administrator is entitled to define those ambiguous terms as long as its interpretation is reasonable. *See King*, 414 F.3d at 999; *Finley v. SpecialAgents Mut. BenefitAss'n, Inc.*, 957 F.2d 617, 621 (8th Cir. 1992). In view of our precedent affirming the reasonableness of a plan administrator denying benefits based on a lack of objective evidence, we cannot say, as a general matter, that it is unreasonable for MetLife to interpret the plan to require provision of objective evidence as part of the "proof' and "documentation" that a claimant must submit.

Having examined the circumstances of this particular case, we also believe it was reasonable on the facts presented here for MetLife to request clinical and objective evidence, and to deny the claim when Pralutsky failed to provide it. MetLife's communications with Pralutsky support its

contention that it was requesting only substantiation of the extent of Pralutsky's disability and not an impossible level of objective proof that she suffered from fibromyalgia. In its initial denial letter, MetLife did not deny Pralutsky's diagnosis, but cited its inability to substantiate "disability so severe to preclude you from returning to your own occupation," and added that "documentation does not support severity of diagnosis for fibromyalgia." (A.R. at 76). MetLife's final denial letter repeated the first letter's statement that medical information did not support "severity of diagnosis," and added that Pralutsky's "significant functional ability to work" was "without substantiation in the medical records." (A.R. at 103). The letter also referred to the absence of "objective medical findings to support the pathology in the musculoske[le]tal or neurological systems," but this was in reference to whether Pralutsky had a "significant functional inability to work," not whether she suffered from fibromyalgia at all.

MetLife's independent physician consultant, Dr. Chou, likewise confirmed the diagnosis of fibromyalgia, but concluded that "[b]ased on the limited medical information regarding the physical examinations, it would be expected that Ms. Pralutsky is able to perform at least sedentary type of work." (A.R. at 100). He concluded:

"The subjective pain and fatigue are consistent with fibromyalgia; however, there is no objective abnormal finding to suggest any defcit or pathology in the neurological or musculoskeletal system *that would preclude her from performing any type of occupation.*" (A.R. at 100) (emphasis added). Pralutsky herself acknowledges that [t]he impact that [fibromyalgia syndrome] has on daily living activities, including the ability to work a full-time job, differs among patients."(Br. of Appellee at 28) (quoting "Fibromyalgia Network"). Given this potential for varying impact of the condition among different patients, MetLife was requesting objective information to verify that this claimant, whom it acknowledged was afflicted with fibromyalgia, was disabled to the point that she could not perform even sedentary or light-duty work

This is not a case in which MetLife unreasonably expected Pralutsky to guess what evidence would satisfy the plan administrator. Met.Life specifically identified and requested additional clinical evidence supporting the severity of Pralutsky's condition. Immediately after she applied for benefits, MetLife wrote a letter describing the information that it required to complete her application, including "treatment records from July 2000 to present" and test results, medication records, and a treatment plan. (A.R. at

65). MetLife directly provided the Fibromyalgia Initial Functional Assessment Form to Dr. Ormiston and sent a fax to both Dr. Tveten and Dr. Ormiston requesting office records from initial evaluation to the present, and information about her current restrictions, prognosis, course of treatment, whether Pralutsky had reached her maximum medical improvement, and whether the doctors would suggest a graduated return to work then or in the future. (A.R. at 56, 72). The nature of the evidence MetLife was seeking was brought to Pralutsky's attention later in the application process as well. In its response to her appeal letter, MetLife indicated that she should provide "treatment records from [her] treating physicians that indicate [her] current treating diagnosis, restrictions and limitations, and ongoing current treatment plans" and "clinical findings and rationale" to support her disability claim. (A.R. at 83).

Reviewing the record as a whole, we conclude that a reasonable person could have reached the same decision as the plan administrator. The administrator had conflicting opinions from Pralutsky's physicians and its independent physician consultant regarding the extent of Pralutsky's limitations, and Pralutsky failed to provide the requested objective evidence that might have established her inability to work. Although Dr. Tveten opined that Pralutsky was

disabled, he did not provide his clinical notes or answer specific questions about his assessment of her prognosis and current functional abilities:. Dr. Ormiston similarly declined to return forms that would have indicated more specifically the nature and severity of Pralutsky's limitations. Pralutsky's counsel suggested at oral argument that MetLife itself could have completed a one-or three-day assessment of her residual functional capacity if MetLife wanted to gather more objective evidence about the severity of her condition but we see no reason why Pralutsky could not have done the same thing herself in response to MetLife's requests for objective evidence. Her suggestion that an RFC assessment would have been useful indicates that it was not impossible to provide objective evidence in support of her claim.

If any one of MetLife's multiple requests for more information had resulted in the submission of office records, or the fibromyalgia assessment form requested by MetLife, or detailed current information about treatment, prognosis, or residual functional capacity, then our analysis may well be different. But in this situation, the evidence before the administrator was limited to letters from two doctors largely repeating Pralutsky's subjective complaints, a normal abdominal and pelvic CT scan, a two-page attending physician statement and one-page supplement, and a general

assessment form that Pralutsky completed herself. When MetLife repeated its request for objective and clinical evidence for consideration of Pralutsky's appeal, the only response it received was a letter from Dr. Tveten repeating Pralutsky's subjective complaints of pain and fatigue. In view of the plan administrator's obligation to protect the plan's trust property by ensuring that disability claims are substantiated, it was not unreasonable for the administrator to require clinical documentation of the sort requested here, and to conclude that Pralutsky had failed to prove that she was disabled under the plan. *See Boardman v. Prudential Life Ins. Co.*, 337 F.3d 9, 16-17 (1st Cir. 2003).

Because we hold that the district court's grant of summary judgment was in error, we also conclude that Pralutsky was not entitled to attorneys' fees and costs under 29 U.S.C. § 1132(g)(1). *See Jackson v. Metro. Life Ins. Co.*, 303 F.3d 884, 890 (8th Cir. 2002).

* * *

The district Court's judgments are reversed, and the case is remanded for entry of judgment in favor of the defendant.

BYE, Circuit Judge, dissenting.

While I agree MetLife did not commit a serious procedural irregularity, I would nevertheless affirm the district under the abuse-of-discretion standard typically applied in ERISA cases. I therefore respectfully dissent.

MetLife abused its discretion when it denied Pralutsky's claim based on a lack of objective evidence she *could not* work, because the record also lacks objective evidence she *could* work. In House v. The Paul Revere Life Ins. Co., 241 F.3d 1045 (8th Cir. 2000), the administrator denied long-term disability benefits alter citing the treating physician's failure to provide "any objective medical findings [or] test data" to support a claim of total disability. 241 F.3d at 1047. We determined the administrator abused its discretion because there was not even a scintilla of evidence refuting the extensive documentation of House's severe heart disease supplied by the specialist who had treated House for a decade." Id. at 1048. Like in House, there is no evidence in this record showing Pralutsky could work. Although the independent review performed by Dr. Chou concluded Pralutsky could function adequately to perform her job, Dr. Chou made that finding solely because of the lack of objective evidence in the record to support the severity of Pralutsky's fibromyalgia

diagnosis. See A.R. at 100 ("Based on the diagnosis of possible fibromyalgia with significant subjective pain and fatigue, Ms, Pralutsky has a mild impairment. The medical records do not provide any objective medical findings to support more significant impairment."). Dr. Chou did not refer to any other evidence to refute the opinions of Pralutsky's treating physicians.

The majority distinguishes House by citing three cases, McGee v. Reliance Standard Life Insurance Co., 360 F.3d 921 (8th Cir. 2004), Hunt v. Metropolitan Life Insurance Co., 425 F.3d 489 (8th Cir. 2005), and Coker v. Metropolitan Life Insurance Co., 281 F.3d 793 (8th Cir. 2002). McGee turned on the combination of the lack of objective evidence *and* the fact McGee's treating psychiatrist and psychologist changed their diagnoses without explanation. See McGee, 360 F.3d at 923, 924-25 (emphasizing the inconsistent nature of the treating physicians' medical records). Coker represents a case in which the claimant's subjective complaints were contradicted by or inconsistent with other record evidence. See Coker, 281 F.3d at 798-99 (noting the record showed Coker had not fainted or experienced a blackout-conditions which allegedly prevented him from working--in several months and concluding "reasonable

physicians could disagree on the extent of Coker's disability"). Finally, I dissented in Hunt for the same reason I am dissenting here, because the plan administrator "abused its discretion in denying benefits based solely on absence of any objective evidence[where] the claimant's subjective complaints are not contradicted by or inconsistent with other record evidence." See Hunt, 425 F.3d at 492 (Bye, J., dissenting).

> [F]ibromyalgia [is] a common, but elusive and mysterious, disease, much like chronic fatigue syndrome, with which it shares a number of features. Its cause or causes are unknown, there is no cure, and, of greatest importance to disability law, its symptoms are entirely subjective. There are no laboratory tests for the presence or severity of fibromyalgia.

Hawkins v. First Union Corp. Long-Term Disability Plan, 326 F.3 d 914, 916 (7th Cir. 2003) (quoting Sarchet v. Chater, 78 F.3d 305, 306-07 (7th Cir.1996). "Objective tests are administered to rule out other diseases, but do not establish the presence or absence of fibromyalgia." Jordan v. Northrup Gumman Corp. Welfare Benefit Plan, 370 F.3d 869, 872 (9th Cir. 2003). In my view, MetLife places too much emphasis on the lack of objective evidence where the issue is the severity of a disability caused by fibromyalgia. In such a case, I believe the plan needs more to deny a claim

than a reviewing physician's opinion based solely upon a lack of objective evidence.

I respectfully dissent.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 04-2409/04-3239

Linda Pralutsky, *

Appellee, * Order Denying

* Petition for Rehearing

v. * En Banc

*

Metropolitan Life *

Insurance Company, *

Appellant.

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

(5128-010199)

March 20, 2006

Order Entered at the Direction of the Court:

Clerk, U.S. Court of Appeals, Eighth Circuit

----------VIA TRANSMISSION----------

United States Court of Appeals
for the Eighth Circuit
Circuit Clerks Office

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